## South Carolina Health Insurance Pool (SCHIP)

## MEDICARE SUPPLEMENT APPLICATION FOR PERSONS UNDER 65

P.O. Box 61173 • Columbia, SC 29260

Phone: In Columbia Area: 803-264-6401 Outside Columbia Area: 800-868-2500, Ext. 46401

Tell Us About Yourself (Please print. Answer all questions	.)					
Social Security Number:		☐ Male ☐ Female	Home Phone Number			
Name	Birthdate	1 1	Email Address			
Address		City	State	Zip		
Which Plan are you Applying for						
Which Plan are you applying for?	☐ Plan C re Administrato	or. (You would need to file	all claims from any other sta	ate directly to us.)		
Billing Information						
How do you wish to be billed?			and attach a voided check	along with your <u>first</u>		
Medicare Information						
Date of enrollment in Medicare Part A:// Please enter your Medicare number, which is on your Medicare			Part B: / /			
Complete Only if Applicant is Under Age 18 or Legally I	ncapacitated					
The Responsible Party applying for this coverage is the application Responsible Party has been a South Carolina resident continuous			parent Legal Guardian	(papers attached)		
Full Name of the Responsible Party	Jusiy Silice	Business Phone	/ Home Pho	ne		
Street Address	Apt#	City	State	Zip		
Eligibility Requirements	<u> </u>	•				
Residency: Applicant must be under age 65, have Medicare P person who has resided continuously in a place of permanent application for supplemental insurance. If the applicant is uncarolina.	t habitation wit	thin the State of South Ca	rolina for at least 30 days in	nmediately before this		
The applicant (and Responsible Party if applicable) must include residency for at least 30 days prior to the date of application: redriver license. The Administrator may request other documentations are the companies of the com	ent receipts, m	ne of the following docume ortgage payment receipts,	ents with the application or of property tax receipts, utility	ther evidence showing bills or South Carolina		
If the applicant is under the age of 18 and enrolled in school or daycare, the Parent or Legal Guardian must include a notarized statement executed by the school or daycare with the application. The notarized statement must include the name of the facility in which the child is enrolled, the facility's address, phone number and the period of time enrolled. If the applicant is not enrolled in school or daycare, the application must include documentation or evidence of residency as requested by the Administrator.						
If the applicant is legally incapacitated, the application must requested by the Administrator.	t include any	documentation or evider	nce of residency available	and/or documentation		
Applicant has been a South Carolina resident continuously since	ce					
Canaumar Drataction Information						

- You may be eligible for benefits under Medicaid and may not need or be eligible for this Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy (or, if that policy is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If your policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that policy is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(continued on back)

	the Best of your Knowledge			
	coverage, the pre-existing condition obtain this coverage, you must car	on exclusion is waived to the extended the other policy.	ent to which similar exclusions, if any, we	erage with the SCHIP Medicare supplement ere satisfied under the prior coverage. If you
1.	(a) If so, with which company?			
	(b) If so, do you intend to replace	your current Medicare suppleme	ent policy with this policy?	Yes No
2.			within the past 63 days? (For example, an er	
	(c) What are your dates of coverage policy, leave "End" blank.)	ge under the policy? START	/ / END / /	(If you are still covered under the other
3.	, ,	ance coverage that you are no I	longer eligible for?	Yes No
	If so, please tell us what kind of p	•	•	
	,	,	, , <u>,</u>	
4.	Medicare HMO or PPO, fill in your s START / / END	start and end dates below. If you ) / /	u are still covered by this plan, leave "En	
			to replace your current coverage with tr	ne new Medicare supplement policy?  Yes No
			dicare plan? (If yes, can	
5				e participating in a "Spend-Down Program"
٥.			uestion	
			plement Policy?	
			AN payments toward your Medicare Par	
DL	ease Read and Sign this Portion	of the Envellment Form		
pre wri I h rep as I a	emium. I certify that in the event I ob tten notification of the coverage and/ pereby authorize the release of all presentative. I also authorize release valid as the original. cknowledge receipt of a SCHIP Medi	otain other comparable health in for my new address to the Admin past and future medical record of Medicare Part A and B clain for a Supplement Outline of Covernment Coutline Covernment Covernm	nsurance or change my residency from nistrator.  ords needed to process this applicat ms information needed to process claims werage, which was provided to me with the surface werage.	ired proof(s) of eligibility and the full initial in the State of South Carolina, I will provide ion or claims to the Administrator, or its s. A photocopy of this authorization shall be the application.
hav	ve or the risk it is assuming on this a	application. I also understand t not have an insurable interes	that no healthcare provider, health e st may be responsible for any prem	ntity, public or private institution, or any ium, deductible or coinsurance for this
	licy.		,	,
Ιu	nderstand that I must be a South (	Carolina resident, have both N	Medicare Parts A and B due to disabil	ity and be under age 65.
Ap	plicant's Signature:	Date Signed	Signature of Responsible Part	ty Date Signed
lf۱	you choose Monthly Bank Draft		agreement below and attach a voide	<u> </u>
	MPANY NAME: South Carolina Hea			NY ID NUMBER: 320410251
			ntries to my checking account below and	
			, ,	a the Bank hamea to debit my deceant.
	CITY	STATE ZIP	BANK ROUTING NUMBER	
			NAME ON ACCOUNT	
the acc hav	is authority is to remain in force untile. Bank a reasonable opportunity to count. If an erroneous debit entry is inverted amount of the entry credited stomer a statement of account or write.	the Bank has received written act on it. A customer has the initiated by the South Carolina I to his/her account by the Baritten notice pertaining to the entitle	notification from me of its termination in right to stop payment of a debit entry lealth Insurance Pool to a customer's a nk. If, within 15 calendar days followin	such time and in such manner as to afford by notifying the Bank prior to charging the account, the customer shall have the right to g the date on which the Bank sent to the accurs first, the customer shall have sent to
PR	INT YOUR NAME	SIGNED X		DATE
	r Use of the Administrator			
. 0	Effective Date	Accept	Reject	Waiver Code
		1.000pt	1.0,000	

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